DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 27

State of Maryland

1. PLACE OF DEATH:
(a) County Anne Arundel
(b) City or town Ft Geo G Meade (If outside city or town limits, write RURAL)
(c) Name of hospital or institution: Company Area (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ In this community 1 Month 18 Days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N J (b) County Gloucester
(c) City or town Gloucester (If outside city or town limits, write RURAL)
(d) Street No. 921 Somerset St (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) FULL NAME Paul ADAMS
3. (b) If veteran, name war World War I
3. (c) Social Security No. –
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mrs Alice B Adams
6. (c) Age of husband or wife if alive – years
7. Birth date of deceased Sept (Month) 12 (Day) 1898 (Year)

8. AGE: Years 47 | Months 1 | Days 7 | If less than one day hr. – min.

9. Birthplace Reading Pa (City, town, or county) (State or foreign country)
10. Usual occupation Soldier
11. Industry or business U S Army

MOTHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)

FATHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Service Record
(b) Address U S Army

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 19 45 (Month) (Day) (Year)
(c) Place; burial or cremation Gloucester NJ
Walter J McCann, Brown & Monmouth St
Undertaker

18. (a) Signature of funeral director Howard Blight
(b) Address 4914 Belair Rd, Balt Md

19. (a) 19 Oct 45 (Date received local registrar) (b) Frank J Tolfsen (Registrar's signature)
Frank J Tolfsen Capt MAC

MEDICAL CERTIFICATION

20. Date of death: Month Oct day 18
year 1945 hour 11 minute 30 AM

21. I hereby certify that I attended the deceased from ~~xxxxxxxxxxxx~~ 19~~xxxx~~ to ~~xxxxxxxxxxxxxxxx~~ 19~~xxxx~~ that I last saw him alive on 18 Oct, 1945 viewed him on
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary Occlusion	Sudden
Due to: Thrombosis	
Due to: Arteriosclerotic heart Disease	
Other conditions: Pulmonary Tuberculosis (Include pregnancy within 3 months of death)	

Major findings:
Of operations –
Of autopsy Confirmed as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: –
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence –
(c) Where did injury occur? – (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? –
While at work? – (Specify type of place) (e) Means of injury –

23. Signature James A McCann (M. D. or other)
Address Reg Hosp Ft Meade Md Date signed 19 Oct 1945

8-0917 U. S. GOVERNMENT PRINTING OFFICE 16—13493

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

Reg. Dist. No. 09693 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 3 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 2 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town unknown
(If outside city or town limits, write RURAL and give nearest town)
Street No. unknown
(If rural, give LOCATION)
2.(a) If veteran, name war unknown

3.(a) FULL NAME ARCHER - JOHN

3.(b) Social Security Number --------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	widower

6.(b) Name of husband or wife --------

6.(c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) 1875 ?

8. AGE: Years 70 ? | Months unknown | Days | If less than one day --- hrs. --- min.

9. Birthplace Maryland ? (Town, county, and state)

10. Usual occupation none

11. Industry or business ---

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Hospital Records

Address Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/26-45 (month) (day) (year)

Cemetery or crematory Hospital

Location Crownsville Md

18. Funeral director Supt. of Hospital

Address Crownsville

19. 10/26 1945 (Date rec'd by registrar) E. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 19 45, at 8:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 8 19 45 to Oct. 11 19 45 and that I last saw him alive on October 11 19 45

Immediate cause of death General Arteriosclerosis — Duration: Prior to Admission

Due to ----------

Due to ----------

Other conditions Senile Psychosis — Known to us since 8/8/45

(Include pregnancy within 3 months of death) --------

Major findings of operations -------- Date of op. -------

Autopsy results ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -------- Date of -------

Where did injury occur? -------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----------

Means of injury ---------- Injured at work? ------

23. SIGNATURE Harold V. Simpson M. D. or other

Address Crownsville, Maryland Date signed 10/11/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-1)

CERTIFICATE OF DEATH

09694

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Parole
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Ann Arundel
City or town: Parole
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
William Bias

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widow

6.(b) Name of husband or wife: Gertrude Bias
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): I843

8. AGE: Years	Months	Days	If less than one day
I02			..... hrs. ..... min.

9. Birthplace: A.A.Co. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Charles Bias
13. Birthplace: A.A.Co.

MOTHER
14. Maiden name: Margrett Owens
15. Birthplace: A.A.Co.

16. Informant: Rachiel Gross
Address: Parole, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. IO, I945 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: Annapolis, Md.

18. Funeral director: J.B.Johnson,
Address: Annapolis, MD.

19. Oct. 9 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 6 19 45, at 1130 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1, 19 45, to Oct 5 19 45
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Carcinoma of Rectum	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Leander H. Johnson M.D. M. D. or other
Address: 40 Northwest Street Date signed 10/9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09695

Reg. Dist. No. 221

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Jessups, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? September 25th, 1945
Hospital, Institution, or street address where death occurred:
Maryland House of Correction Hosp.
How long in hospital or institution? 10/11/45 to 10/31/45

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St Marys
City or town: Unknown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: William Boone

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Single

6.(b) Name of husband or wife: None
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 15, 1880

8. AGE: Years	Months	Days	If less than one day
65	1	16	..... hrs. ..... min.

9. Birthplace: St Marys Co Md (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Unknown
13. Birthplace:
MOTHER 14. Maiden name: Unknown
15. Birthplace:
16. Informant: Md. House of Correction
Address: Jessups, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 19, 1945 (month) (day) (year)
Cemetery or crematory: Cherry Hill Cemetery
Location: Jessups, Md.
18. Funeral director: H. L. Collins
Address: Jessup, Md
19. Nov 19 1945 (Date rec'd by registrar) Registrar: Edna Haslup

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31st 1945 at 3.10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/11/45 to 10/31/45
and that I last saw him alive on 10/31/45

Immediate cause of death	DURATION
Congestive heart failure, Mitral insuff.	
Pulmonary tuberculosis	
### chronic, upper lobes both lungs & lower lobe right lung.	
Due to: Duration undetermined	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No operations
Date of op.
Autopsy results: Not done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: John A Clark M.D.
M.D. or other
Address: Jessup, Maryland Date signed: 10/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

09696

★ Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Weems Creek

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Weems Creek

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Margaret Bemiss Bryan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Samuel Bryan

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 11 1865

8. AGE:

Years	Months	Days	If less than one day
79	10	6	hrs. min.

9. Birthplace: Clarksville Penn. (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Dr. Samuel M. Bemiss

13. Birthplace: Ky.

MOTHER — 14. Maiden name: Mary Frances Lockert

15. Birthplace: Penn.

16. Informant: Mrs W.P.C. Clarke

Address: Weems Creek A A Co Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 20, 1945 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va

18. Funeral director: John M. Taylor's Son

Address: Annapolis Md.

19. Oct. 20 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 18 1945 at 3 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1 1945, to Oct 18 1945

and that I last saw her alive on Oct. 8 1945

Immediate cause of death	DURATION
Myocarditis & Myocardial Degeneration	Several years
Due to	
Due to	
Other conditions Arteriosclerosis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Geo C Bunch M. D. or other

Address: Annapolis Md Date signed 10-22-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 09697 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs., 8 mos., 26 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 4 yrs., 8 mos., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: --------

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 907 Pier Street
(If rural, give LOCATION)

2.(a) If veteran, name war: unknown ✓

3.(a) FULL NAME: BUCK - JAMES

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	widower

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1891

8. AGE: Years	Months	Days	If less than one day
54	unknown		--- hrs. -- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Stevedore

11. Industry or business: --------

FATHER
12. Name: Thomas Young
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annie M. Buck
15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial ✓, cremation, or removal. Which? Date thereof 10-26-45 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Supt

Address: Crownsville Md

19. 10/26/45 (Date rec'd by registrar) E. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18 1945, 11:05A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 22 1941, to Oct. 18 1945 and that I last saw him alive on October 18 1945

Immediate cause of death	DURATION
General Paresis	Known to us since 2/10/41
Due to: --------	
Due to: --------	
Other conditions: --------	

(Include pregnancy within 3 months of death)

Major findings of operations: ---------

Date of op.: ------

Autopsy results: ---------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --------- Date of: -----

Where did injury occur? ---------
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -----

Means of injury: --------- Injured at work? -----

23. SIGNATURE: Herbert J. Whitehead M. D. or other

Address: Crownsville, Maryland Date signed: 10/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (91-B)

CERTIFICATE OF DEATH

09698

Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel Co.

City or town Jessup (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles Lee Carroll.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	C	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31 1928

8. AGE: Years 17 Months Days If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation [redacted] Laborer

11. Industry or business Cleaning Brushes

FATHER 12. Name Lloyd Carroll

13. Birthplace Maryland.

MOTHER 14. Maiden name Mary Cheney

15. Birthplace Maryland.

16. Informant Mary Carroll

Address Jessup Rd. [redacted]

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-15-45 (month) (day) (year)

Cemetery or crematory Lawsonia

Location Jessup Md.

18. Funeral director Edgar F. MacGaffin

Address Catonsville Md.

19. Oct 14 1945 (Date rec'd by registrar) Clara Mastin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/7/45 to 10/11 1945

and that I last saw h[illegible] alive on 10/11 1945

Immediate cause of death	DURATION
Acute Endocarditis	3
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. B. Funnell M. D. [illegible]

Address Laurel Date signed 10/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

09699

CERTIFICATE OF DEATH

★ Reg. Diat. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 807 Bay Ridge Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Arthur McDowell Carter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Anna M. Carter
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 13th 1891

8. AGE: Years	Months	Days	If less than one day
53	10	8	hrs. min.

9. Birthplace Annapolis Md (Town, county, and state)
10. Usual occupation Clerk at Annapolis
11. Industry or business Post Office
FATHER 12. Name Arthur B. Carter
FATHER 13. Birthplace Annapolis Md.
MOTHER 14. Maiden name Permelia Mount
MOTHER 15. Birthplace A. A. Co. Md.
18. Informant Anna M. Carter
Address Eastport A. A Co Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 24th 1945 (month) (day) (year)
Cemetery or crematory Cedar Bluff Cemetery
Location Annapolis Md.
18. Funeral director John W. Taylor & Son
Address Annapolis Md.
19. Oct 23 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 19 45 at 8:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 21 19 45 to Oct 21 19 45 and that I last saw him alive on Oct 21 19 45

Immediate cause of death	DURATION
Coronary Dilatation of Heart	Sudden
Due to Cr. Myocarditis	Several Months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE K. Oliver Parvis M. D. or other
Address Annapolis Md Date signed 10/22/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

09700

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel Co

City or town: Glen Burnie. Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs mos.

Hospital, institution, or street address where death occurred: No

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A.A. Co

City or town: Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

Street No. 314 Oak Lane

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME John Edward Carter

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs Caroline Carter

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Aug 25, 1870

8. AGE:

Years	Months	Days	If less than one day
75	1	23	— hrs. — min.

9. Birthplace: A.A. Co. Md.
(Town, county, and state)

10. Usual occupation: Farmer - Retired

11. Industry or business: Farming

FATHER
12. Name: Van Buren Carter
13. Birthplace: A.A. Co Md.

MOTHER
14. Maiden name: Mary E. Barber
15. Birthplace: A.A. Co.

16. Informant: Mrs Edna Sears
Address: Glen Burnie — Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 19-1945 (month) (day) (year)

Cemetery or crematory: Baltimore Mem Company

Location: A.A. Co.

18. Funeral director: Ronald G. Georgetown
Address: Glen Burnie Md

19. Oct 18 1945 (Date rec'd by registrar) M. Scalba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 17 1945, at 6:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Oct 17 1945 and that I last saw him alive on Oct 16 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 mos
Due to: Cardio. Vascular Disease	5 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James S. Bellagha MD M. D. or other

Address: Glen Burnie Md Date signed Oct 17, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

69761

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 125 Prince George Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 125 Prince George St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Bettie E. Catlin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William E. Catlin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 7, 1868

8. AGE:

Years	Months	Days	If less than one day
77	1	3	..... hrs. ..... min.

9. Birthplace: Annapolis, A. A. Co. Md.

(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: John Crutchley

13. Birthplace: A. A. Co. Md.

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Miss Louise Catlin

Address: Prince George St. - Anna.

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 12, 1945 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis, Md.

18. Funeral director: John M. Taylor & Son

Address: Annapolis, Md.

19. Oct. 12 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10 1945, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1945 to Oct. 10 1945

and that I last saw h... on ... alive on Oct. 10, 1945

Immediate cause of death ..... DURATION

(a) Coronary Thrombosis

Due to: (b) Chronic Myocarditis

Due to: (c) Cause Unknown

Other conditions: Arteriosclerosis Cardiac

(Include pregnancy within 3 months of death)

Major findings of operation: Bilateral Mastectomy ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Albert H. Anderson M.D.

M. D. or other

Address: Annapolis, Md. Date signed: 10/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37a)

CERTIFICATE OF DEATH

09702

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Millersville, Md. R.F.D. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 1/2 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Benfield (Millersville Md.) R.F.D. (If outside city or town limits, write RURAL and give nearest town)

Street No.: Crain Highway (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: William N. Chalk

3.(b) Social Security Number: 214-18-1848

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: none

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 23, 1911

8. AGE: Years	Months	Days	If less than one day
33	9	10	..... hrs. ..... min.

9. Birthplace: Laurel, Md. (Town, county, and state)

10. Usual occupation: Freight Driver's Helper

11. Industry or business: Service Express, Balto. Md.

FATHER — 12. Name: William L. Chalk

FATHER — 13. Birthplace: Laurel Md.

MOTHER — 14. Maiden name: Mary C. Chalk

MOTHER — 15. Birthplace: Laurel, Md.

16. Informant: Mrs William L. Chalk

Address: Millersville Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 6. 1945 (month) (day) (year)

Cemetery or crematory: Ivy Hill Cemetery

Location: Laurel, Md.

18. Funeral director: Thomas W. Langston

Address: Glen Burnie, Md.

19. Oct 4 1945 (Date rec'd by registrar) M. Deale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 3 1945 at 5.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/11/45 1945 to 10/3/45 1945 and that I last saw h alive on 10/1/45. 1945

Immediate cause of death	DURATION
Pulmonary Edema	Few days
Acute Suppression of urine.	
Due to: Chronic Interstitial Nephritis	Ten Years
Due to: Chronic Endocarditis	
Other conditions: Acute Alcoholism.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: John L. Alexander M. D. or Other

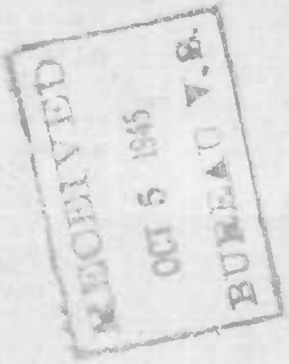
Address: Glen Burnie, Md. Date signed 10/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

acute suppression
of Urine



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

09703

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs., 2 mos., 20 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 4 yrs., 2 mos., 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Crisfield
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route #2, Box #38
(If rural, give LOCATION)

2.(a) If veteran, name war: --------

3. (a) FULL NAME

CHAMBERS - SARAH (Stella)

3. (b) Social Security Number --------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: Harrison Chambers,

Grasonville, Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1883

8. AGE: Years	Months	Days	If less than one day
62	unknown		---- hrs. ---- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: --------

FATHER
12. Name: Levin Athinson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Hannah Hargis
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Oct. 29, 1945 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Baltimore City

18. Funeral director: William A. Jackson
Address: 916 Pennsylvania Ave., Balto., Md.

19. Oct-29-45 (Date rec'd by registrar) 1945 E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 21 1945, at 5:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31 1941, to Oct. 21 1945 and that I last saw her alive on October 21 1945

Immediate cause of death	DURATION
Chronic Myocarditis	Apprx. 6 mos.
Due to: --------	
Due to: --------	
Other conditions: Senile Psychosis	Known to us since 7/31/41

(Include pregnancy within 3 months of death)

Major findings of operations: ----------

Date of op. -------

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -------- Date of: -------

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----------

Means of injury ---------- Injured at work? -----

23. SIGNATURE: Albert A. Smith Exam M. D. or other

Address: Crownsville, Maryland Date signed: 10/21/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09704

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME William Carrick

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	B.	widowed

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ~~1859~~ ? 1859

8. AGE: Years	Months	Days	If less than one day
86 ?			hrs. min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business
FATHER 12. Name: William Carrick
13. Birthplace: Md
MOTHER 14. Maiden name: unknown
15. Birthplace:
16. Informant: Hospital Records
Address: Crownsville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-10-45 (month) (day) (year)
Cemetery or crematory: Mt. Hebron
Location: Balt. Md.
18. Funeral director: Frances A. Hemsley
Address: 518 W. Biddle St.
19. 10-6- 1945 (Date rec'd by registrar) E. J. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 6, 1945, at 11.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 7, 1945, to October 6, 1945
and that I last saw h.... alive on October 6, 1945

Immediate cause of death	DURATION
General Paresis	Unknown to us since 9-7-45
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Herbert V. Hinrichs M. D. or other
Address: Crownsville Date signed 10-6-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

09705

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:
County Anne Arundel
City or town Earleigh Heights (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State New York County
City or town New York (If outside city or town limits, write RURAL and give nearest town)
Street No. 2142 - 5th Avenue (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Reginald Creasey
3.(b) Social Security Number 073-12-9823

4. Sex Male
5. Color or race Negro
6.(a) Single, married, widowed, or divorced single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Nov. 18. 1919
8. AGE: Years 25 Months 11 Days 0 If less than one day ... hrs. ... min.
9. Birthplace Flushing, Long Island N.Y. (Town, county, and state)
10. Usual occupation Chauffeur
11. Industry or business private auto
FATHER 12. Name Benjamin Creasey
13. Birthplace Utica N.Y.
MOTHER 14. Maiden name Mary Judson
15. Birthplace Orangeburg. S.C.
16. Informant Carrie Thomas.
Address 1 W. 131 St. New York, N.Y.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 / 1 / 45 (month) (day) (year)
Cemetery or crematory New York C. N.Y.
Shipped Location New York City N.Y.
18. Funeral director Mrs Charles E. Hick
Address 45 Northwest St Annapolis Md
19. Oct. 19 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18 1945, at 2:50 A.M.
21. I CERTIFY that death occurred on the date above stated; Postmortem Examination Oct. 18 1945

Immediate cause of death	DURATION
Cardio-renal	
Due to disease	9 weeks
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Claffy M.D. Deputy Medical Examiner M.D. or other
Address Annapolis, Md Date signed 10-18-45

I

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-C)

CERTIFICATE OF DEATH

09706

★ Reg. Dist. No. 22

1. PLACE OF DEATH: A. A. G.

County: Harmans (Harmans)

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 hrs.

Hospital, institution, or street address where death occurred: Matthewstown.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Harmans Rural (If outside city or town limits, write RURAL and give nearest town)

Street No.: Matthewstown (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Marie Irene Day

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col.	Single

6.(b) Name of husband or wife: ✓

7. Birth date of deceased (mo., day, yr.): Oct 14th 1945

6.(c) If alive, give age: years

8. AGE: Years: 0 | Months: 0 | Days: 1 | If less than one day: hrs. min.

9. Birthplace: Harmans, A. A. Co., Md. (Town, county, and state)

10. Usual occupation: ✓

11. Industry or business: ✓

FATHER — 12. Name: James Queen

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Irene Day

MOTHER — 15. Birthplace: Md.

16. Informant: Irene Day

Address: Harmans. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/15/45 (month) (day) (year)

Cemetery or crematory: On premises.

Location:

18. Funeral director: Geo. Day, acting

Address: Harmans. Md.

19. Oct 15 1945 (Date rec'd by registrar) Edara Haslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 15th 1945 at 4 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 14th 1945 to Oct. 15th 1945

and that I last saw h[illegible] alive on Oct. 14th 1945

Immediate cause of death: Congenital Atelectasis — Duration: 1 Day

Due to: Dystrophia

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frank S. Shipley, M. D. M. D. or other

Address: Savage. Md. Date signed: 10/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

09707

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Dorsey Rd
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs

Hospital, Institution, or street address where death occurred:
Race Rd

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Anne Arundel

City or town: Dorsey (Hanover P.O.)
(If outside city or town limits, write RURAL and give nearest town)

Street No. Race Rd. R.F.D.
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3. (a) FULL NAME William Dodd.

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary Louisa A. Ball Dodd

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): July 6 - 1860

8. AGE: Years: 85 | Months: 2 | Days: 26 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Liverpool England
(Town, county, and state)

10. Usual occupation: Ship builder

11. Industry or business: Retired

FATHER
12. Name: William Dodd.
13. Birthplace: Liverpool England

MOTHER
14. Maiden name: ?
15. Birthplace

16. Informant: Mrs Laura M. Dobrecka
Address: Box 100C - Hanover Md R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/6/45 (month) (day) (year)

Cemetery or crematory: Oaklawn Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 10/4 45 (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 2 1945, at 6 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 1944, to Oct 2 1945

and that I last saw h.. alive on Oct 1 1945

Immediate cause of death	DURATION
Chr. Myocarditis	5 yrs
Mitral Insufficiency	5 yrs
Due to: Generalized Arteriosclerosis	10 yrs
Due to: Senility	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 609 Main St Elkridge Md Date signed 10/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09708

(157.6)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correctly. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: a. a.

City or town: annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 Days

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 12 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn Infants give residence of mother)

State: Maryland County: a. a.

City or town: Epping Forest Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Near annapolis

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Margaret Donaldson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 15 1945

8. AGE: Years | Months | Days: 17 | If less than one day: hrs. min.

9. Birthplace: annapolis md (Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER — 12. Name: Ulysses G. Donaldson

FATHER — 13. Birthplace: Churchville md

MOTHER — 14. Maiden name: Margaret A Pons

MOTHER — 15. Birthplace: Indianapolis Ind

16. Informant: Ulysses G Donaldson

Address: Epping Forest

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 3/45 (month) (day) (year)

Cemetery or crematory: St Mary's

Location: annapolis md

18. Funeral director: B-L Hopkins

Address: annapolis md

19. Oct 3 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 2 1945 at 10 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1945 to October 2 1945 and that I last saw h... alive on October 2 1945

Immediate cause of death	DURATION
1 – Spina bifida	Since birth
Due to: Congenital deformity	
Due to:	
Other conditions: Congenital disease	Since birth
Fatal Atelectasis	Hours

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert R Anderson M.D. M. D. or other

Address: Annapolis Md Date signed: 10/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (84C)

09709 P

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 yrs, 4 mos, 22 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 13 yrs., 4 mos., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: La Plata (If outside city or town limits, write RURAL and give nearest town)

Street No. ------- (If rural, give LOCATION) -------

2.(a) If veteran, name war:

3. (a) FULL NAME: DORSEY - MARTHA

3. (b) Social Security Number: ---------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: -------

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1899

8. AGE: Years	Months	Days	If less than one day
46	unknown		--- hrs. --- min.

9. Birthplace: unknown (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: -------

FATHER — 12. Name: unknown

FATHER — 13. Birthplace: unknown

MOTHER — 14. Maiden name: unknown

MOTHER — 15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-27-45 (month) (day) (year)

Cemetery or crematory: Mt Auburn

Location: Balto Md.

18. Funeral director: A. Halstead

Address: 918 E. Druid Hill Ave.

19. 10/26 1945 A. Halstead Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 20 19 45, at 9:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 19 32, to Oct. 20 19 45 and that I last saw her alive on October 20 19 45

Immediate cause of death	DURATION
Schizophrenic Exhaustion	
Due to: ----------	
Due to: ---------	
Other conditions: Schizophrenia - catatonic type (Include pregnancy within 3 months of death)	Known to us since 5/28/32

Major findings of operations: ---------- Date of op. -----

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------- Date of: -----

Where did injury occur? --------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---------

Means of injury: ---------- Injured at work? -----

23. SIGNATURE: Albert J. Winterode M. D. or other

Address: Crownsville, Maryland Date signed: 10/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

09710

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution or street address where death occurred:
Emergency Hospital
How long in hospital or Institution? dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County:
City or town: Meyersdale
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mary K. Edmunds

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife: Dr. Geo. H. Edmunds
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 27, 1878

8. AGE: Years	Months	Days	If less than one day
67	4	11	hrs. min.

9. Birthplace: Clarksville Allegany Co. Penna
(Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business: Home

FATHER
12. Name: Frank Maley
13. Birthplace: Germany

MOTHER
14. Maiden name: Wilhelmina Cissesta
15. Birthplace: Germany

16. Informant: Mrs Anna J. Maley
Address: 3707 Bexmue Av., Baltimore Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct 8th 1945 (month) (day) (year)

Cemetery or crematory:
Location: Meyersdale Penn.

18. Funeral director: W. C. Price
Address: Meyersdale Penn

19. Oct 8 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 7 1945 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~I last attended deceased from~~ Post mortem 19 Examination ~~and that I last saw him alive on~~ Oct. 7 1945

Immediate cause of death	DURATION
Acute dilatation of Heart	sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

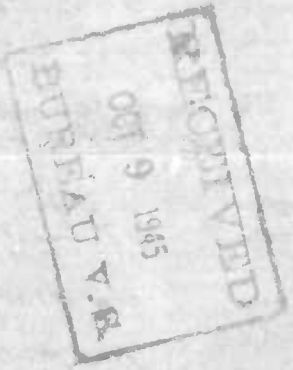
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner
M.D. or other
Address: Annapolis, Md. Date signed: 10/7/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(H) MARGIN RESERVED FOR BINDING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OCT 9 1965
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

09711

CERTIFICATE OF DEATH

Reg. Diat. No. 71

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
State Circle
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: State Circle
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Burleigh Clayton Fooks

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Eleanor A. Fooks
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 7, 1897

8. AGE: Years	Months	Days	If less than one day
47	11	18	hrs. min.

9. Birthplace: Salisbury, Md.
(Town, County, and state)
10. Usual occupation: clerk - Ration board
11. Industry or business

FATHER
12. Name: Burnell M. Fooks
13. Birthplace: Maryland

MOTHER
14. Maiden name: Emily Lee Shockley
15. Birthplace: Maryland

16. Informant: Mrs. Eleanor Fooks
Address: State Circle

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 26, 1945 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis, Md.
18. Funeral director: John M. Taylor and Son
Address: Annapolis Md.

19. Oct. 26 1945 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 25 1945, at 1a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 1 1945, to Oct. 25 1945
and that I last saw him alive on Oct. 24 1945

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to	
Due to	
Other conditions: Moderate arterio-sclerosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: George C. Boxil M. D. or other
Address: Annapolis Md. Date signed 10. 26. 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

09712

Reg. Diat. No. .....

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years 7 months 1 day
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 8 years 7 months 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: .....
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 931 Woodyear Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Annie Foster

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Separated

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: ~~61~~ years
7. Birth date of deceased (mo., day, yr.): 1884

8. AGE: Years: 61 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business:
FATHER 12. Name: Robert Eaton
13. Birthplace: North Carolina
MOTHER 14. Maiden name: Nellie Downing
15. Birthplace: North Carolina
18. Informant: Hospital Records
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10 - 9 - '45 (month) (day) (year)
Cemetery or crematory: Mt. Ambrose Cem.
Location: Baltimore, Md.
18. Funeral director: Mrs. Katie R. Williams
Address: 322 N. Schroeder St.
19. Oct 9 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 6 1945, at 7.40 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 1937, to October 6 1945
and that I last saw h.. alive on October 6 1945

	DURATION
Immediate cause of death: Chronic Myocarditis	Between 1 to 10 since March 5, 1937
Due to:	
Due to:	
Other conditions: Senile Dementia	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: Herbert D. Armstrong M. D. or other
Address: ..... Date signed: .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

09713

CERTIFICATE OF DEATH ★

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? Short

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 103 Charles Street
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Victor Vaughn Fowler

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Marguerite Anna Fowler

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): October 29, 1900

8. AGE: Years	Months	Days	If less than one day
44	11	6	....hrs. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Electrician (Naval Academy)

11. Industry or business

FATHER — 12. Name: Joseph Fowler

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary Stevens

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Victor Fowler

Address: 103 Charles Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 7, 1945 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Maryland

18. Funeral director: John M. Taylor and Son

Address: Annapolis, Md.

19. Oct. 7 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 5 1945, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1, 1945, to Oct 5 1945

and that I last saw him alive on Oct 4 1945

Immediate cause of death	DURATION
Carcinoma Liver	1 mo.
Primary	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geo. C. Boeil, M. D. or other

Address: Annapolis Md. Date signed: 10-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94

CERTIFICATE OF DEATH

09714

Reg. Dist. No. 21

1. PLACE OF DEATH:

County a a

City or town annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

60 Southgate ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 60 Southgate ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Aaron Lee Goodman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Jeanette C. Goodman

6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) May 12 1873

8. AGE:

Years	Months	Days	If less than one day
72	5	5	hrs. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER

12. Name Moses Goodman

13. Birthplace Lithuania

MOTHER

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Jeanette C. Goodman

Address 60 Southgate ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 19 45 (month) (day) (year)

Cemetery or crematory Kenesth Israel

Location 3 mile oak

18. Funeral director B L Hopkins

Address Annapolis

19. Oct. 18 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17th 1945 at 3:15 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 3/45 to Oct 17 1945

and that I last saw h... alive on Oct 17 1945

	DURATION
Immediate cause of death	
Coronary Thrombosis	Indefinite
Due to: Coronary Sclerosis	Indefinite
Due to: Fatal Attacks	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Oliver Purvis M. D. or other

Address Annapolis Md Date signed 10/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

09715

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:
County: Anna Arundel
City or town: Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4203 Ritchie Highway
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Howard Emory Gray

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Lillie Brinkman
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 3, 1869

8. AGE: Years	Months	Days	If less than one day
76	2	7	hrs. min.

9. Birthplace: Rock Hall, Kent Co. Md.
(Town, county, and state)
10. Usual occupation: Coal Dealer
11. Industry or business

FATHER
12. Name: J. W. Gray
13. Birthplace: Rolandmille, Cecil Co., Md.

MOTHER
14. Maiden name: Johanna Foster
15. Birthplace: Baltimore, Co., Md.

16. Informant: Mrs Lillie Gray
Address: 4203 Ritchie Highway

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 15, 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Ritchie Highway
18. Funeral director: John F. Dennis, Inc.
Address: 715 Light St.

19. Oct. 13 19 45 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10, 19 45, at 9.10p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 9 19 44, to Sept 24 19 45
and that I last saw h. alive on Sept 24 19 45

Immediate cause of death	DURATION
Hypertension and Arteriosclerosis	14 years
Due to: Preliminary Element	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Nelson Casey M.D.
M. D. or other
Address: 1014 St Paul St Date signed: 10-13-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

09716

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
32 Gotts Court

How long in hospital or institution? ********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 32 Gotts Court
(If rural, give LOCATION)

2.(a) If veteran, name war: World War 1

3.(a) FULL NAME: John Henry Green

3.(b) Social Security Number: 214-05-2002

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife: ********

6.(c) If alive, give age: ****** years

7. Birth date of deceased (mo., day, yr.): August 29 1898

8. AGE: Years	Months	Days	If less than one day
47 47			....hrs. ....min.

9. Birthplace: Iglehart A. A. Co. Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: None

FATHER
12. Name: Frank Green
13. Birthplace: Eastern Shore Maryland

MOTHER
14. Maiden name: Martha Gross
15. Birthplace: Iglehart A. A. Co. Md.

16. Informant: Sherman Green
Address: 1413 Columbia St. N. W. Washington D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/24/45 (month) (day) (year)

Cemetery or crematory: National Cemetery

Location: West St. Extd.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest Annapolis Md.

19. Oct. 24 19 45 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 21 19 45 at 2 45 P.M

21. I CERTIFY that death occurred on the date above stated: Postmortem Examination Oct. 21 19 45

Immediate cause of death	DURATION
Coronary occlusion	Sudden
Due to: Coronary sclerosis	Unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John N. Cleffy M.D. Deputy Medical Examiner
M. D. or other

Address: Annapolis Md. Date signed: 10/23/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

CERTIFICATE OF DEATH

09717

★ Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? dead on arrival
Hospital, Institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Crownsville Nutwell
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Thomas Edward Gross

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	negro	married

6.(b) Name of husband or wife: Elizabeth Gross
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.):

8. AGE:

Years	Months	Days	If less than one day
42	2	17	hrs. min.

9. Birthplace: Shady Side, Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: Daniel Gross
13. Birthplace: Germany
MOTHER 14. Maiden name: Cornelia Holland
15. Birthplace: Shady Side, Md
16. Informant: Elizabeth Gross
Address: Crownsville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 11 1945 (month) (day) (year)
Cemetery or crematory: Union Chapel
Location: Mc Kendree, Md
18. Funeral director: J. G. Snowden & Son
Address: Galesville Md
19. Oct. 8 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 7, 1945 at 10 03 P. M

21. I CERTIFY that death occurred on the date above stated; [redacted] Post mortem & Examination Oct. 7, 1945

	DURATION
Immediate cause of death: Bullet wound in Chest	
Due to: and abdomen	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of 10-7-45
Where did injury occur? Crownsville (City or town) Anne Arundel (County) Maryland (State)
Injured at home, farm, industry, public place (where?): near Bennett Tavern
Means of injury: 38 cal. bullet Injured at work? no

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md Date signed: 10-7-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09718 Reg. Diat. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs., 6 mos., 22 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 5 yrs., 6 mos., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1819 Presstman Street
(If rural, give LOCATION)
2.(a) If veteran, name war: --------

3. (a) FULL NAME: HALL - MILFORD

3. (b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: -----
6.(c) If alive, give age: --- years
7. Birth date of deceased (mo., day, yr.): 1903

8. AGE: Years	Months	Days	If less than one day
42	unknown		--- hrs. --- min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Shoe-shiner
11. Industry or business: -------

FATHER
12. Name: Milford Hall
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Kester
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-27-45 (month) (day) (year)
Cemetery or crematory: East Ridge Lawn
Location: N. ?

18. Funeral director: George W. Nelson
Address: 1303 Presstman St

19. 10/25 1945 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 23 1945 at 2:10 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 1 1940 to Oct. 23 1945 and that I last saw him alive on October 23 1945

Immediate cause of death: Tuberculosis of the Lungs — DURATION: Known to us since 10/12/45
Due to: ---------
Due to: ---------
Other conditions: Epilepsy — Known to us since 4/1/40
(Include pregnancy within 3 months of death)

Major findings of operations: ----------
Date of op.: -------
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------- Date of: ------
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: ---------- Injured at work? -------

23. SIGNATURE: Hal V. Bamford M. D. or other
Address: Crownsville, Maryland Date signed: 10/23/45

Boail

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

09719

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

1. PLACE OF DEATH:

County a a

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 years

Hospital, Institution, or street address where death occurred:
5 Cathedral St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County a a

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5 Cathedral St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Frida Hambrock

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife William Hambrock

6.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) March 9 — 1865

8. AGE: Years	Months	Days	If less than one day
80	7	20	....hrs. ....min.

9. Birthplace ~~New York~~ Germany
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Fridericka Braun
15. Birthplace Germany

16. Informant William Hambrock
Address 5 Cathedral St

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 1 45 (month) (day) (year)

Cemetery or crematory St Mary's

Location Annapolis. Md.

18. Funeral director B E Hopkins

Address Annapolis. Md.

19. Nov. 1 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 19 45 at 6 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 27 19 45, to Oct 29 19 45 and that I last saw h~~er~~ alive on Oct 29 19 45

Immediate cause of death	DURATION
Myocarditis acute	3 days
Due to Arteriosclerosis	unknown
Due to	
Other conditions Colecystitis	Several years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Boail
M. D. or other

Address Annapolis Md Date signed 10.31.45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

09720

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
6I Shaw St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A.A.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6I Shaw St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charlotte G. Henson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife: Tobias Henson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. I5, I864

8. AGE: Years	Months	Days	If less than one day
80	I0	5	..... hrs. ..... min.

9. Birthplace: A. A. Co. Md. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: John Goodrich
13. Birthplace: A.A.Co.

MOTHER
14. Maiden name: Charlotte Goodrich
15. Birthplace: A.A.Co. Md.

18. Informant: Pearl Henson
Address: 935 Saratoga St., Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct., 24, I945 (month) (day) (year)
Cemetery or crematory: Asbury Cemetery
Location: Annapolis, Md.
18. Funeral director: J.B.Johnson.
Address: Annapolis, Md.

19. Oct. 23 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 20 19 45 at 10 00 A. M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem Examination 19 ..... ~~and that I last saw h~~ ..... alive on Oct. 20 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	Sudden
Due to: Cerebral arterio-sclerosis	Unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: John M. Coffey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md. Date signed 10/22/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09721

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Gambrills Md. R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14. Mo
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Gambrills
(If outside city or town limits, write RURAL and give nearest town)
Street No. Kings, Farm.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: George Edward Hobbs.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	SINGLE

6.(b) Name of husband or wife
B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): January 27, 1943

8. AGE:

Years	Months	Days	If less than one day
2	8	4	hrs. min.

9. Birthplace: Montgomery Co, Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Ahren B. Hobbs
13. Birthplace: Lee Co. Va.

MOTHER
14. Maiden name: Alpha Patton
15. Birthplace: Knoxville Tenn.

16. Informant: Ahren B. Hobbs
Address: Gambrills, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-2-45 (month) (day) (year)
Cemetery or crematory: Church of God Cemetery
Location: Gambrills, Md

18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. Oct 2 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1 1945, at 6 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19, to 19
and that I last saw h alive on 9-22 1945

Immediate cause of death	DURATION
Meningitis, Tuberculosis	2 1/2 wks
Due to: Tuberculosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Mary Ophelia Cruise, M.D.
M. D. or other
Address: A A County Health Dept. Date signed 10-1-45
Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

09722

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83d)

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 yrs., 5 mos., 4 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 24 yrs., 5 mos., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ---------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. unk. (Came from Bay View)
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown ✓

3.(a) FULL NAME: HOLDEN - WALTER

3.(b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

B.(b) Name of husband or wife: ---------
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1894

8. AGE: Years: 51 | Months: uhknown | Days: | If less than one day: --- hrs. --- min.

9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business: -----
FATHER 12. Name: unknown
13. Birthplace: unknown
MOTHER 14. Maiden name: unknown
15. Birthplace: unknown
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. burial (Burial, cremation, or removal. Which?) Date thereof 9/26-45 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md
18. Funeral director: Dept.
Address: Crownsville
19. 9/26 1945 E. Joyce Local Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10 1945, at 8:15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6 1921, to Oct. 10 1945
and that I last saw h. in alive on October 10 1945

	DURATION
Immediate cause of death: Hemiplegia	1 mo.
Due to: General Arteriosclerosis	Apprx/ 2 yrs.
Due to: ----------	
Other conditions: Psychosis with Mental Deficiency (Include pregnancy within 3 months of death)	Known to us since 5/6/21

Major findings of operations: ---------
Date of op. ------
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of: ------
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Manne of injury: ---------- Injured at work? -----

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 10/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

09723

CERTIFICATE OF DEATH

Reg. Diat. No. 24

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 5 mos., 12 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 1 yr., 5 mos., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ---

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 843 W. Lexington St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3. (a) FULL NAME: HOPKINS - HERMAN

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Susie Hopkins, 843 W. Lexington St., Balto.

6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1888 ?

8. AGE: Years	Months	Days	If less than one day
57 ?	unknown		--- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER — 12. Name: Ernest Hopkins

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Julia Mitchell

MOTHER — 15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year): 10 12 45

Cemetery or crematory: Mt Calvary

Location: Balto Md.

18. Funeral director: Adolphus Halstead

Address: 918 Druid Hill Ave

19. Oct 9- 19 45 (Date rec'd by registrar) Oct 11 1945 — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8 19 45 at 9:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26 19 44, to October 8 19 45 and that I last saw him alive on October 8 19 45

Immediate cause of death	DURATION
Generalized Arteriosclerosis	Known to us since 4/26/44
Due to: ---	
Due to: ---	
Other conditions: Psychosis with Cerebral Arteriosclerosis (Include pregnancy within 3 months of death)	Known to us since 4/26/44

Major findings of operations: ---

Date of op.: ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) --- (County) --- (State)

Injured at home, farm, Industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Adolphus Halstead M. D. or other

Address: Crownsville, Maryland Date signed: 10/8/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

09724 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:
County Anne Arundel
City or town Curtis Bay
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Sparrows Point Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 630 E - Street
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Charles L. Hutton

3.(b) Social Security Number 213-07-7600

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Unknown
6.(c) If alive, give age Unknown years

7. Birth date of deceased (mo., day, yr.) Dec. 10. 1901

8. AGE: Years	Months	Days	If less than one day
43	10	7	hrs. min.

9. Birthplace Blacksburg Va.
(Town, county, and state)
10. Usual occupation Pipe fitter
11. Industry or business U.S. Coast Guard
FATHER 12. Name Charles L. Hutton Sr.
13. Birthplace Va.
MOTHER 14. Maiden name Nannie Monohue
15. Birthplace Va.
16. Informant Mrs Joseph M. Kite
Address Westminster Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/19/45 (month) (day) (year)
Cemetery or crematory Wakefield Cemetery
Location Blacksburg, Va.
18. Funeral director John F Henry Inc
Address 715 Light St.
19. 10/18 19 45 A W Kedrick (Date rec'd by registrar) S-M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 19 45 at 7-10 A M

21. I CERTIFY that death occurred on the date above stated: ~~I attended deceased from~~ Post mortem Examination and that I last saw ~~deceased alive on~~ Oct. 17 19 45

Immediate cause of death	DURATION
Coronary Occlusion	Sudden
Due to Coronary Sclerosis	unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John N. Cagley M.D. Deputy Medical Examiner
M. D. or other
Address Annapolis Md. Date signed 10-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (115-6)

CERTIFICATE OF DEATH

09725

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Skidmore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: Skidmore, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Skidmore, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Pauline Insey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1910.

8. AGE: Years	Months	Days	If less than one day
35	9	12	..... hrs. ..... min.

9. Birthplace: Skidmore, Md. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER — 12. Name: James Insey.

FATHER — 13. Birthplace: A.A.Co.

MOTHER — 14. Maiden name: Bessie Johnson

MOTHER — 15. Birthplace: A.A.Co.

16. Informant: Bessie Insey

Address: Skidmore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct, 15, 1945 (month) (day) (year)

Cemetery or crematory: Broadneck Cemetery

Location: Skidmore, Md.

18. Funeral director: J.B.Johnson.

Address: Annapolis, Md.

19. Oct, 15, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct, 12, 1945 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 1945, to Oct 12 1945

and that I last saw h... alive on ..... 19....

Immediate cause of death	DURATION
Streptococcus Throat	3 da.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Charles B. Johnson M. D. or other

Address: 46 Northwest Street Date signed 10/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

09726

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Edgewater

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Edgewater

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Edgewater

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Edgewater

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Marie A. Jarosik

3. (b) Social Security Number: 10 12 25

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John F. Jarosik

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 4, 1862

8. AGE: Years	Months	Days	If less than one day
83	3	19	..... hrs. ..... min.

9. Birthplace: Prague (Town, county, and state)

10. Usual occupation: None

11. Industry or business: —

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Adolph Jarosik

Address: R.F.D. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 25, 1945 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md.

18. Funeral director: John M. Taylor and Son

Address: Annapolis, Maryland

19. 10-25-45 (Date rec'd by registrar) Edward Colburn Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 23 19 45, at 5 20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 19 45, to Oct 23 19 45

and that I last saw h[illegible] alive on Oct 22 19 45

Immediate cause of death	DURATION
Myocardosis + Myocardial Thrombosis	unknown
Due to: Arteriosclerosis	unknown
Due to:	
Other conditions: Bronchial asthma	many yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Geo. C. Bond M. D. or other

Address Annapolis md Date signed 10-24-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09727

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Jessups, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 65 days
Hospital, institution, or street address where death occurred:
MARYLAND HOUSE OF CORRECTION
How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: None
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME
WILLIE (WILLIAM) JONES

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col'd	Single

8.(b) Name of husband or wife: None
6.(c) If alive, give age: Dec. 25, 1879 years
7. Birth date of deceased (mo., day, yr.): Dec. 25, 1879

8. AGE: Years	Months	Days	If less than one day
65	9	24	hrs. min.

9. Birthplace: Atlanta, Ga.
(Town, county, and state)
10. Usual occupation: Stevedore
11. Industry or business

FATHER
12. Name: Henry Jones
13. Birthplace: Unknown

MOTHER
14. Maiden name: Hannah
15. Birthplace: Unknown

16. Informant: MARYLAND HOUSE OF CORRECTION
Address: Jessups, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 1st 1945 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Cherry Hill
18. Funeral director: Harry L. Cleary
Address: Jessups, Md.
19. Oct 31 1945 (Date rec'd by registrar) McDaniel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 19 1945 at 10:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6 1945 to October 19 1945 and that I last saw him alive on October 19 1945

Immediate cause of death	DURATION
Congestive heart failure.	
Due to Mitral insufficiency	
Due to Arterio-sclerosis, general, severe.	
Other conditions Paralysis, partial, left arm and leg, result of cerebral apoplexy about 2 months ago.	

(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John A Clark M D
M. D. or other
Address: M H C Date signed: Oct 29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09728 P

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Bar Harbor (Rock Creek)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? unknown
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: on his boat in Rock Creek
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Keller

3.(b) Social Security Number 217-14-9570

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1891

8. AGE: Years 54 | Months 1 | Days 24 | If less than one day ..... hrs. ..... min.

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual occupation: Fishing
11. Industry or business: Sea-food
FATHER 12. Name: Bernard Keller
FATHER 13. Birthplace: District of Columbia
MOTHER 14. Maiden name: Ida Jeffries
MOTHER 15. Birthplace: Virginia
16. Informant: From Birth Certificate (Copy)
Address: City of Baltimore
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 10/20/45 (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: Woodlawn, Md.
18. Funeral director: F. C. Wisner & Son
Address: 300 Eastern Ave. Baltimore
19. OCT 8 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 17, 1945 at 5:35 P. M.
21. I CERTIFY that death occurred on the date above stated; ~~that I last attended deceased from~~ to Post mortem Examination Oct. 17, 1945 and that I last saw ~~him alive on~~

Immediate cause of death	DURATION
Ruptured Appendicitis	
Due to: Drowning	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 10-17-45
Where did injury occur? Bar Harbor (City or town) Anne Arundel (County) Md. (State)
Injured at home, farm, industry, public place (where?) Rock Creek
Means of Injury: fell off pier into water Injured at work? yes

23. SIGNATURE: John M. Coffy M.D. Deputy Medical Examiner (M. D. or Other)
Address: Annapolis Md. Date signed 10-17-45

STATE OF MARYLAND—CERTIFICATE OF DEATH 09729

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No.

Village or City Brooklyn No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Herman M. Lang If U. S. Veteran, specify WAR

(a) Residence: No. 5417 Virginia Ave St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
M	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Schmaltz

6. DATE OF BIRTH (month, day, and year) Aug 14 1876

7. AGE	Yeers	Months	Days	If LESS than 1 day, hrs. or min.
	69	1	18	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. None.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Germany

FATHER

13. NAME John Lang

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME Ernestine Fritz

16. BIRTHPLACE (city or town) (State or country) Germany

17. INFORMANT Mrs. Mary Lang

(Address) 5417 Virginia Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Glen Haven Date 10/6/45, 19

19. UNDERTAKER Fisher Bros

(Address) 1318 Light St.

20. FILED 10-5-45, 19 Registrar. Certificate

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH October 2d, 1945 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 13, 1945, to Oct. 2, 1945

I last saw him alive on Oct 2, 1945; death is said to have occurred on the date stated above, at 9 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Hypertensive cardio vascular disease	2
Other Contributory Causes of Importance: Chronic asthmatic bronchitis	2

Name of operation None Date of

What test confirmed diagnosis? P. M. Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Harry Deibel M. D.

(Address) 1206 Hanover St.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09730

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs., 2 mos., 25 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 4 yrs., 2 mos., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ------

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: -------

3.(a) FULL NAME: LEWIS - MARSHALL

3.(b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

8.(b) Name of husband or wife: unknown

8.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1876

8. AGE: Years	Months	Days	If less than one day
69	unknown		--- hrs. -- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) burial Date thereof 11-5-45 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Dept

Address:

19. (Date rec'd by registrar) NOV 5 1945 E. Hope Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 19 45, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31 19 41, to Oct. 26 19 45 and that I last saw him alive on October 26 19 45

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to: -------	
Due to: -------	
Other conditions: Senile Psychosis - Simple Deterioration (Include pregnancy within 3 months of death)	Known to us since 7/31/41

Major findings of operations: -------

Date of op.: -----

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------- Date of: -----

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -------

Means of injury: ---------- Injured at work? ----

23. SIGNATURE: Albert L. Winkelman M. D. or other

Address: Crownsville, Maryland Date signed: 10/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

9731

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr, 1 mo, 13 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 1 yrs, 1 mo, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ------

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 755 W. Mulberry Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3. (a) FULL NAME: MASON - HERMAN R.

3. (b) Social Security Number: ---------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Bernice Mason, 755 W. Mulberry St., Balto. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1902

8. AGE: Years	Months	Days	If less than one day
43	unknown		---- hrs. ---- min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business: ------

FATHER — 12. Name: Harry Mason

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Bett Chandler

MOTHER — 15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof oct. 20-45 (month) (day) (year)

Cemetery or crematory: Mt. Calvery

Location: A.A. Co.

18. Funeral director: Elroy O. Wilson

Address: 1000 Brantly ave

19. Oct 27 45 (Date rec'd by registrar) E.T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26 19 45 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 13 19 44 to Oct. 26 19 45 and that I last saw him alive on October 26 19 45

Immediate cause of death: General Paresis — DURATION: Known to us since 9/26/44

Due to: --------

Due to: --------

Other conditions: --------

(Include pregnancy within 3 months of death)

Major findings of operations: ----------

Date of op.: -----

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -------- Date of: -----

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---------

Means of injury: ---------- Injured at work? -----

23. SIGNATURE: Herbert J. Montgomery M. D. or other

Address: Crownsville, Maryland Date signed: 10/26/45


RECEIVED
OCT 30 1945
BUREAU

Evidence for the change of birth date is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1246)

09733

FILM No. G 98 OCT 19 1945

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Two and 1/2 months
Hospital, institution, or street address where death occurred:
U.S. Naval
How long in hospital or institution? 2 1/2 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Dorchester
City or town Vienna
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war World War I or II

3. (a) FULL NAME McCULLEY-JAMES LUTHER

3. (b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Wh	Married

6.(b) Name of husband or wife Emma Louise McCulley

7. Birth date of deceased (mo., day, yr.) Dec 30, 1892 — Feb 6-1897

6.(c) If alive, give age 48 years

8. AGE:

Years	Months	Days	If less than one day
52	9	8	..... hrs. ..... min.

9. Birthplace Evansville, Tenn.
(Town, county, and state)
10. Usual occupation Engineer — Naval Officer
11. Industry or business Power Plant —
12. FATHER Name William McCulley
13. FATHER Birthplace Tenn.
14. MOTHER Maiden name Mary A. Neil
15. MOTHER Birthplace Tenn.
16. Informant Mrs. J. L. McCulley
Address Vienna, Md.
17. Burial, cremation, or removal. Which? Removal Date thereof Oct 8/45 (month) (day) (year)
Cemetery or crematory Unknown
Location Cambridge, Md.
18. Funeral director B L Hopkins
Address Annapolis, Md.
19. Oct. 8 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1945 at 7-20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21 1945, to Oct 7 1945 and that I last saw h. alive on 10-6 1945

Immediate cause of death	DURATION
Cirrhosis of Liver	8 mo
Due to	
Due to	
Other conditions Acute Nephritis	2 days

(Incinde pregnancy within 3 months of death)

Major findings of operations none.
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury Injured at work?

23. SIGNATURE Ron Harris - Md.
Address USN Hosp. Annapolis Md M. D. or other
Date signed 10-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

09732

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 13 Dean Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A. Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 13 Dean Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Jennie Wade McCready

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William B. McCready
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 22, 1864

8. AGE: Years	Months	Days	If less than one day
81	5	1	hrs. min.

9. Birthplace: Crisfield, Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: Riley Byrd
13. Birthplace: Crisfield, Md.

MOTHER
14. Maiden name: Sally J. Corbin
15. Birthplace: Crisfield, Md.

16. Informant: William M. McCready
Address: 13 Dean St - Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 25, 1945 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis, Md.
18. Funeral director: John M. Taylor & Son
Address: Annapolis, Md.
19. 10-25 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 23 1945, at 9:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1938, to Oct 23 1945
and that I last saw her alive on Oct 23 1945

Immediate cause of death	DURATION
Myocarditis & Myocardial Degeneration	7 years
Due to	
Due to	
Other conditions: Arteriosclerosis	chronic

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. C. Boyle M. D. or other
Address: Annapolis Md. Date signed: 10-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (184)

CERTIFICATE OF DEATH

09734

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Barbersville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred: .....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Spencerville
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME: Lacy L. Merson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	single

6.(b) Name of husband or wife: none
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 22 1930

8. AGE: Years: 14 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Montgomery Co Md
(Town, county and state)

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name: Randolph Merson
13. Birthplace: Montgom Co Md

MOTHER
14. Maiden name: Malme E. Corby
15. Birthplace: Virginia

16. Informant: Randolph Merson
Address: Spencerville Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Oct 31 1945 (month) (day) (year)
Cemetery or crematory: Union Cemetery
Location: Buntown Ville Md

18. Funeral director: Riddle Selby
Address: 401 Washington Lane Md

19. Oct 31 1945 (Date rec'd by registrar) M. Beacheer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 28 1945 at 6 00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post mortem Examination Oct 28 1945
and that I last saw h alive on .....

Immediate cause of death	DURATION
Shot-gun wound	
Due to: Face and head	Sudden
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? ..... Date of 10-28 45
Where did injury occur? Barbersville (City or town) A.A. (County) Md (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: Shot-gun wound Injured at work? .....

23. SIGNATURE: John M. Cluff M.D Deputy Medical Examiner
M. D. or other.
Address: Annapolis Date signed: 10-28-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09735

Reg. Diat. No. 2E

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs, 5 mos, 12 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 15 yrs, 5 mos, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: -------

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 821 Edmondson Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: ---------

3. (a) FULL NAME: MOSELY - JULIA

3. (b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: John Mosely, 740 West Franklin St., Balto. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1871

8. AGE: Years: 74 | Months: unknown | Days: | If less than one day: ---hrs. ---min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ------

FATHER
12. Name: Ben Brown
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Ellen Brooks
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Oct. 16, 1945 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Baltimore City

18. Funeral director: Joseph A. Livly Jos A. Livly

Address: 661 W. Barre St., Balto., Md.

19. Oct 15, 19[illegible] (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11 19 45 at 5:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 29 19 30 to Oct. 11 19 45 and that I last saw her alive on October 11 19 45

Immediate cause of death	DURATION
Lung Tuberculosis	Known since 7/6/38
Due to: ----------	
Due to: ----------	
Other conditions: Senile Psychosis	Known to us since 4/29/30

(Include pregnancy within 3 months of death)

Major findings of operations: --------- Date of op.: ------

Autopsy results: ---------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --------- Date of: -------

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----------

Means of injury: ---------- Injured at work? -------

23. SIGNATURE: Fred V. Whitcomb M. D. or other

Address: Crownsville, Maryland Date signed: 10/11/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

09736

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Eastport Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 35 years
Hospital, institution, or street address where death occurred:
101 Eastern Ave.
How long in hospital or institution? ********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel Co.
City or town: Eastport Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 101 Eastern Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Anthony Murray

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband or wife: **********
6.(c) If alive, give age: *****years

7. Birth date of deceased (mo., day, yr.): July 4, 1875

8. AGE: Years	Months	Days	If less than one day
70 70	4	30	....hrs. ....min.

9. Birthplace: Hopes Chapel A. A. Co. Md.
(Town, county, and state)
10. Usual occupation: Fisherman
11. Industry or business: None

FATHER
12. Name: William Murray
13. Birthplace: Hopes Chapel A. A. Co. Md.

MOTHER
14. Maiden name: Milinda Johnson
15. Birthplace: Hopes Chapel A. A. Co. Md.

16. Informant: Catherine Ellen Pettigrew
Address: 101 Eastern Ave. Eastport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/ 2/ 45 (month) (day) (year)
Cemetery or crematory: Annapolis Neck Cemetery
Location: Annapolis Neck

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. Nov. 2 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 30 19 45 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Postmortem Examination to ..... 19.... ~~and that I last saw him alive on~~ ..... 19....

Immediate cause of death	DURATION
Cardio-renal disease	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? .....

23. SIGNATURE: John M. Caffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md. Date signed 10-31-45

09737

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Skidmore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? LIFE

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Ann Arundel

City or town: Skidmore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Naomie Murray

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 3, 1927

8. AGE: Years	Months	Days	If less than one day
18	6	2	..... hrs. ..... min.

9. Birthplace: Skidmore, A.A.Co. Md. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER — 12. Name: George Murray

13. Birthplace: Skidmore, Md.

MOTHER — 14. Maiden name: Mammie Murray

15. Birthplace: Skidmore, Md.

16. Informant: Mammie Murray

Address: Skidmore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 9, 1945 (month) (day) (year)

Cemetery or crematory: Broadneck

Location: Skidmore, Md.

18. Funeral director: J.B.Johnson

Address: Annapolis Md.

19. Oct 9 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 5 19 45 at 7.30 A. (or P.) M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25 1945, to Oct 5 1945

and that I last saw h.. alive on Oct 5 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 mon
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Theodore H. Johnson M. D. or other

Address: 40 Northern Street Date signed 10/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

09738

2411 N. Charles St., Baltimore (176-c)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: 3½ miles from Millersville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? sudden death
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Odenton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James Alvin Nelson Norris

3.(b) Social Security Number: 216-18-3479

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): July 15, 1914

8. AGE: Years	Months	Days	If less than one day
31	3	8	hrs. min.

9. Birthplace: Herring Creek, St. Marys Co. Md.
(Town, county, and state)
10. Usual occupation: Driver - Truck
11. Industry or business: Reliable Contracting Co.

FATHER
12. Name: Alvin C. Norris
13. Birthplace: Holly Wood, St. Marys Co. Md.

MOTHER
14. Maiden name: Madge R. Clark
15. Birthplace: St. Marys Co. Md

16. Informant: Robert E. Norris
Address: Odenton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 26, 1945 (month) (day) (year)
Cemetery or crematory: St. Marys Lady of the Field
Location: Millersville, A.A. Co. Md.
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. Oct 25 1945 (Date rec'd by registrar) Mae Alba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 23, 1945 at 7:40 M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post-mortem Examination 19 ~~and that I last saw him alive on~~ Oct. 23 1945

Immediate cause of death	DURATION
Fracture base of Skull	
Multiple fractures of chest	
Left pleurisy left ~~lung~~ clavicle	
and left scapula left arm	
Due to: Hemorrhage	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 10-23-45
Where did injury occur? Near Millersville Ft. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place, (where?) Crain Highway
Means of injury: auto collision Injured at work? No

23. SIGNATURE: John M. Ribbby M.D
M. D. or other
Address: Annapolis, Md. Date signed 10-23-45

Deputy Medical Examiner

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


NOV 1 1945
BUREAU P.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

09739

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs, 10 mos, 25 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 2 yrs, 10 mos, 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: ---
City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)
Street No.: 1039 Argyle Avenue (If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: NORTHERN - AMANDA

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	separated

6.(b) Name of husband or wife: ---
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): January 4, 1910

8. AGE: Years	Months	Days	If less than one day
35	9	15	-- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: ---

FATHER
12. Name: George Northern
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lena Petty
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 23, 1945 (month) (day) (year)
Cemetery or crematory: St. Michael's Cemetery
Location: St. Michaels, Maryland
18. Funeral director: J. Norman Marshall
Address: St. Michaels, Maryland

19. Oct. 20 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 19 1945 at 8:25P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 24 1942 to Oct. 19 1945 and that I last saw her alive on October 19 1945

Immediate cause of death	DURATION
General Paresis	Known to us since 1/8/42
Due to: ---	
Due to: ---	
Other conditions: ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) --- (County) --- (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Wm. J. Hinkelmann M. D. or other
Address: Crownsville, Maryland Date signed: 10/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09740 28
Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, institution, or street address where death occurred:
Cronwsville State Hospital
How long in hospital or institution? 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick County
City or town: 321 E. Church Street
(If outside city or town limits, write RURAL and give nearest town)
Street No. Frederick, Maryland
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3. (a) FULL NAME: Parker - Emma V.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: James W. Parker
6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1894

8. AGE: Years	Months	Days	If less than one day
51	unknown		---- hrs. --- min.

9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: housework
11. Industry or business: ------

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?), Date thereof 11-3-1945 (month) (day) (year)
Cemetery or crematory: Fairview Cem.
Location: Frederick, Md.

18. Funeral director: M. R. Etchinson
Address: Frederick Md Local

19. Oct 31 45 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31, 1945 at 4:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 1945 to Oct. 31 1945 and that I last saw her alive on October 31 1945

Immediate cause of death	DURATION
Chronic Myocarditis	known to us since 7/30/45
Due to: --------	
Due to: ---------	
Other conditions: Presenile Psychosis- Delirious and Confused Type (Include pregnancy within 3 months of death)	known to us since 7/30/45

Major findings of operations: -----
Date of op. ---
Autopsy results: ------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -------- Date of ----
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -----
Means of injury ------ Injured at work?

23. SIGNATURE: Herbert V. Finnegan M. D. or other
Address: Crownsville, Maryland Date signed: 10/31/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-C)

09741

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County a a

City or town West annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred:

712 Billings ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town West annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 712 billings ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles F. Payne

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Edna P. Payne

6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Dec 10 1880

8. AGE: Years	Months	Days	If less than one day
64	10	19	....hrs. ....min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Gen Foreman Gas

11. Industry or business Electric Co

FATHER 12. Name William T Payne

13. Birthplace Va

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Edna P Payne

Address 712 Jillings ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/1/45 (month) (day) (year)

Cemetery or crematory Baltimore

Location Baltimore Md

18. Funeral director B F Hagberg

Address annapolis Md

19. Oct 31 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 1945 at 12-30 P. M.

21. I CERTIFY that death occurred on the date above stated: Postmortem Examination

and that my last attendance was on Oct. 29 1945

Immediate cause of death	DURATION
Bullet wound in head	minutes
Due to Suicide	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident; suicide, or homicide Suicide Date of 10-29-45

Where did injury occur? West Annapolis, A. A. Maryland (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury .38 cal. bullet Injured at work? no

23. SIGNATURE John N. Coffey M.D. Deputy Medical Examiner (M. D. or other)

Address Annapolis Md Date signed 10-31-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09742

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Churchton Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 years
Hospital, institution, or street address where death occurred: Churchton Md. A. A. Co.
How long in hospital or institution? ********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel Co.
City or town: Churchton Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Churchton Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: **********

3.(a) FULL NAME: Addie Peal

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Widow

6.(b) Name of husband or wife: **********
6.(c) If alive, give age: ***years

7. Birth date of deceased (mo., day, yr.): July 16, 1875

8. AGE: Years	Months	Days	If less than one day
70	3	6	....hrs. ....min.

9. Birthplace: Churchton Md. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: None

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs Vergie Thomas
Address: Churchton Md. A. A. Co.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/25/45 (month) (day) (year)
Cemetery or crematory: Branklin Chapel Cemet ry
Location: Churchton Md. A. A. Co.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. 10-26 (Date rec'd by registrar) 19 45 J. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22 1945, at 3:50 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 15, 1945 to October 22, 1945
and that I last saw h.r alive on October 22, 1945

Immediate cause of death: Chronic Myocarditis — DURATION: July 15, 1945

Due to:

Due to:

Other conditions: Arterio-Sclerosis
(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: R. L. Richardson M. D. or other
Address: Annapolis Md. Date signed: 10/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09743

Reg. Diat. No. .....

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years, 4 months, 9 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 4 years, 4 months, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: .....
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1040 Eden Street
(If rural, give LOCATION)
2.(a) If vete an, name war: .....

3. (a) FULL NAME: John Pinkett

3. (b) Social Security Number: .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	B.	married

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1902

8. AGE:

Years	Months	Days	If less than one day
43			..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Porter
11. Industry or business:
FATHER 12. Name: John Pinkett
13. Birthplace: Md
MOTHER 14. Maiden name: Unknown
15. Birthplace:
16. Informant: Hospital Records
Address: Crownsville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-10-45 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Baltimore - Md.
18. Funeral director: Mrs Ida Bailey
Address: 1421 Jefferson Street
19. 10/8/45 (Date rec'd by registrar) 19.. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7, 1945, at 9:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29, 1941 to October 7, 1945 and that I last saw him alive on October 7, 1945

Immediate cause of death	DURATION
General Paresis	Unknown
Due to:	since admission
Due to:	5-29-41.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Md. Date signed 10-7-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45)

09744

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Rural Glambilles
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Rural Glambilles
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Jacob Pokorny

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

6.(b) Name of ~~husband~~ or wife: Anna (nee Rachova)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): april 14 - 1863

8. AGE: Years: 82 | Months: 5 | Days: 14 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Czechoslovakia (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Not known
13. Birthplace

MOTHER 14. Maiden name: Last Known
15. Birthplace

18. Informant: Josephine Dixon
Address: Glambilles R F D

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/4/45 (month) (day) (year)
Cemetery or crematory: Sacred Heart Cem.
Location: German Hill Rd. Balto. Md.

18. Funeral director: Charles E. Schimunek
Address: 2601 E. Madison Street

19. Oct 3 1945 (Date rec'd by registrar) A W Heyduck Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1st 19 45 at 1.30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 9 45 to Oct 1st 19 45
and that I last saw h[illegible] alive on Sept 30 19 45

Immediate cause of death	DURATION
Cancer of mouth and throat	10 Mos
Due to: Primary in mouth. Then to esophagus. Cause	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: O'Mac Kenan M D (M. D. or other)
Address: Millersville Md Date signed 10-1-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

09746

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 yrs, 11 mos, 1 day

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 22 yrs, 11 mos, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: unknown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: ---------

3. (a) FULL NAME: RICHARDSON - ELLA

3. (b) Social Security Number: ----------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: --------

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1895

8. AGE: Years	Months	Days	If less than one day
50	unknown		---- hrs. ---- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ------

FATHER
12. Name: Robert Richardson
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 11/5/45 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Duff

Address

19. M-5 1945 — E. Joyce Local
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24 19 45, at 9:45 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 23 19 22, to Oct. 24 19 45

and that I last saw her alive on October 24 19 45

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to: ---------	
Due to: ---------	
Other conditions: Manic Depressive Psychosis	Apprx. 23 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ---------

Date of op.: -----

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --------- Date of: ----

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----------

Means of injury: ---------- Injured at work? -----

23. SIGNATURE: Walter V. Woodcock M. D. or other

Address: Crownsville, Maryland Date signed: 10/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

09747

★ Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 301 Fourth Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 301 Fourth Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Harry Rosati

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elsie R. Rosati

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 15, 1900

8. AGE: Years	Months	Days	If less than one day
45	7	9	hrs. min.

9. Birthplace: Old Point Comfort, Va.

(Town, county, and state)

10. Usual occupation: employed at Experiment Sta.

11. Industry or business

FATHER — 12. Name: Joseph A. Rosati

13. Birthplace: Italy

MOTHER — 14. Maiden name: Filipia Delia

15. Birthplace: Italy

16. Informant: Elsie R. Rosati

Address: 301 Fourth Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 26th 1945 (month) (day) (year)

Cemetery or crematory: St Mary's

Location: Annapolis, Md

18. Funeral director: John M. Taylor & Son

Address: Annapolis, Md.

19. 10-25-45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 23 19 45 at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 45, to Oct 23 19 45

and that I last saw him alive on Oct 23 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to	
Due to	
Other conditions Moderate Arteriosclerosis	Years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: George C Boyd M. D. or other

Address Annapolis Md Date signed Oct 24 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93rd)

09748 P

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH: A. A. Co.
County .....
City or town Harvey
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs.
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A. Co.
City or town Harvey
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Letitia J. Rowland

3.(b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife Hall Edward
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) July 27, 1853.

8. AGE: Years 92 Months 3 Days ..... If less than one day ..... hrs. ..... min.

9. Birthplace Va.
(Town, county, and state)
10. Usual occupation .....
11. Industry or business .....
FATHER 12. Name Robt. L. Blackburn
13. Birthplace Va.
MOTHER 14. Maiden name Endora Skelton
15. Birthplace Va.
16. Informant Mrs. Lillian O'Brien
Address 2906 N. Loudon Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 30/45 (month) (day) (year)
Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.
18. Funeral director Harry H. Mitkle
Address 4401 Edmondson Ave.
19. 10/30 1945 Authorized Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27th 1945, at 4 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1st 1945 to Oct. 27th 1945
and that I last saw h[illegible] alive on October 26th 1945

Immediate cause of death	DURATION
Chr. Myocarditis	1 yr.
Due to Arteriosclerosis	5 yr.
Due to	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations ✓
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Frank Shipley, M.D.
M. D. or other
Address Savage, Md. Date signed 10/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Paid

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7-d)

09749

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County a a

City or town Homewood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25

Hospital, institution, or street address where death occurred: 1100 maple st

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town Homewood

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1100 Maple ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Schlegel

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	mard

6.(b) Name of husband or wife Emma M Schlegel

6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Sept 19 1886

8. AGE: Years	Months	Days	If less than one day
59	1	10	hrs. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Geo Schlegel

13. Birthplace Balto Md

MOTHER 14. Maiden name anna Bonnet

15. Birthplace Balto Md

16. Informant Emma M Schlegel

Address 1100 maple ave Homewood

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 1/45 (month) (day) (year)

Cemetery or crematory Glenn memorial Assn

Location Glen Burnie

18. Funeral director B. E. Hagans

Address Annapolis Md

19. Nov 1 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1945 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1937 to Oct 29 1945 and that I last saw h. alive on Oct 29 1945

Immediate cause of death	DURATION
Myocardits & Myocardial Thrombosis	8 yrs
Due to Hypertension	
Due to	8 yrs
Other conditions Arteriosclerosis	8 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George A Bond M. D. or other

Address Annapolis Md Date signed 10-31-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09750

Reg. Dist. No. 28

1. PLACE OF DEATH:
County Anne Arundel
City or town Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs, 3 mos, 25 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 4 yrs, 3 mos, 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County ------
City or town Baltimore City (If outside city or town limits, write RURAL and give nearest town)
Street No. 1019 Leadenhall Street (If rural, give LOCATION)
2.(a) If veteran, name war World War I ✓

3.(a) FULL NAME Hipolito SEMIDAY, SEMIDAY, HIPPOLITO (Semiday, Hippolito)

3.(b) Social Security Number --------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife Lucille Semiday, 1019 Leadenhall St., Balto. 6.(c) If alive, give age unk years

7. Birth date of deceased (mo., day, yr.) 1904 ?

8. AGE: Years	Months	Days	If less than one day
41 ?	unknown		---hrs. --min.

9. Birthplace Puerto Rico (Town, county, and state)

10. Usual occupation Musician

11. Industry or business ------

FATHER
12. Name Betaliano Semiday
13. Birthplace Puerto Rico

MOTHER
14. Maiden name Dominga ?
15. Birthplace Puerto Rico

16. Informant Hospital Records
Address Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Oct. 18, 1945 (month) (day) (year)
Cemetery or crematory Mt. Calvary Balto. Nat. Cem. Frederick ave., Baltimore, Md.
Location Anne Arundel County

18. Funeral director Walter B. Spriggs
Address 139 W. Hamburg St., Balto., Md.

19. 10/16 45 (Date rec'd by registrar) 19.... E. Joyce Rae Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1945 at 1:55 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 20 1941 to Oct. 15 1945 and that I last saw him alive on October 15 1945

	DURATION
Immediate cause of death: General Paresis	Known to us since 7/7/41
Due to: --------	
Due to: --------	
Other conditions: --------	

(Include pregnancy within 3 months of death)

Major findings of operations: ----------
Date of op. --------
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of -----
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ----------
Means of injury ---------- Injured at work? ----

23. SIGNATURE Hubert D. Smith M. D. or other
Address Crownsville, Maryland Date signed 10/15/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

09751

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 1 day
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 2 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: -----
City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)
Street No. 522 Calhoun Street (If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: SHORT- ROBERT

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: -------

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1875-? 1881

8. AGE: Years	Months	Days	If less than one day
64 -3-?	unknown		---- hrs. ---- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Butler

11. Industry or business: ---

FATHER
12. Name: William Short
13. Birthplace: Maryland

MOTHER
14. Maiden name: Jane Hammond
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 14/45 (month) (day) (year)
Cemetery or crematory: Mt. Auburn Cemetery
Location:

18. Funeral director: Mrs. Robert Elliott + Daughter
Address: 1129 N. Caroline St.

19. Oct. 13 1945 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11 1945 at 1:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 10 1945 to October 11 1945 and that I last saw him alive on October 11 1945

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to: General Arteriosclerosis	Prior to adm.
Due to: --------	
Other conditions: Senile Psychosis - Simple Deterioration	Known to us since 8/10/45

(Include pregnancy within 3 months of death)

Major findings of operations: --------
Date of op.: -----
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -------- Date of: -----
Where did injury occur? -------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---------
Means of injury: ---------- Injured at work? -----

23. SIGNATURE: Albert V. Winkelmeyer M. D. or other
Address: Crownsville, Maryland Date signed: 10/11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

09752 Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years or more
Hospital, Institution or street address where death occurred: 17 Shrine Court
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A. A. Co.
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 17 Shrine Court
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Elizabeth Brooks Simms

3. (b) Social Security Number: 214-05-2852

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Widow

6.(b) Name of husband or wife
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): March 1896

8. AGE: Years	Months	Days	If less than one day
49 49	7		hrs. min.

9. Birthplace: Millswamp A. A. Co. Md (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: Home

FATHER
12. Name: William Brooks
13. Birthplace: Millswamp A. A. Co Md.

MOTHER
14. Maiden name: Rose Foote
15. Birthplace: Millswamp A. A. Co. Md.

16. Informant: Mrs Agnes Brown
Address: 17 Shrine Court

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 (month) 14 (day) 45 (year)
Cemetery or crematory: Brewhill Cemetery
Location: West St. Extd.
18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest Annapolis Md.

19. Oct. 12 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11 1945 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 16 1945 to October 11 1945 and that I last saw h.ex.ative on October 11 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 5 mon
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dr. Theodore H. Johnson M.D. (M. D. or other)
Address: 48 Northwest Street Date signed: 10/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State File No. 10745
Registrar's No. 27

State of Maryland

1. PLACE OF DEATH:
(a) County Anne Arundel
(b) City or town Fort George G. Meade (If outside city or town limits, write RURAL)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 1 year 5 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County Germany
(c) City or town Burlegenfeld (If outside city or town limits, write RURAL)
(d) Street No. 8 Kallmuergustrasse (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) FULL NAME Georg Steigler POW
3. (b) If veteran, name war –
3. (c) Social Security No. –

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife –
6. (c) Age of husband or wife if alive – years
7. Birth date of deceased April (Month) 24 (Day) 1922 (Year)

8. AGE: Years 23 Months 5 Days 20 If less than one day hr. min.

9. Birthplace Unknown (City, town, or county) (State or foreign country)
10. Usual occupation Prisoner of War
11. Industry or business –

MOTHER FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature 201-File
(b) Address Prisoner of War Camp
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/45 (Month) (Day) (Year)
(c) Place: burial or cremation Post Cemetery Fort George G. Meade, Md
18. (a) Signature of funeral director Howard M. Blight Jr.
(b) Address 4914 Belair Road
19. (a) 15 Oct 45 (Date received local registrar) (b) Frank J. Tollison (Registrar's signature)
FRANK J. TOLLISON CAPT MAC

MEDICAL CERTIFICATION
20. Date of death: Month October day 13
year 1945 hour 6:00 minute 10 PM
21. I hereby certify that I attended the deceased from – , 19 , to – , 19 :
that I last saw him alive on 13 October , 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Occlusion	Sudden
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Confirmed as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) –
(b) Date of occurrence –
(c) Where did injury occur? – (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? –
While at work? – (Specify type of place) (e) Means of injury –

23. Signature Dee R. Parkinson M. D.
Address Regional Hosp Ft Meade Md Date signed 15 Oct 1945

8-6917 U. S. GOVERNMENT PRINTING OFFICE 16—13403

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

09753

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 16 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 month, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St. Mary's
City or town: Hollywood
(If outside city or town limits, write RURAL and give nearest town)
Street No.: -------
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: STEVENS - MARY

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: -------

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1910 ?

8. AGE: Years	Months	Days	If less than one day
35 ?	unknown		--- hrs. --- min.

9. Birthplace: unknown (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: -----

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Oct. 31, 1945 (month) (day) (year)
Cemetery or crematory: St. John's
Location: Hollywood, Maryland

18. Funeral director: P. B. Robinson
Address: Leonardtown, Maryland

19. 10/30/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 28 1945 4:20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 13 1945 to Oct. 28 1945 and that I last saw her alive on Oct. 28 1945

Immediate cause of death	DURATION
Chronic Myocarditis	Known to us since 9/13/45
Due to: ---------	
Due to: ---------	
Other conditions: Schizophrenia	Known to us since 9/13/45

(Include pregnancy within 3 months of death)

Major findings of operations: ---------
Date of op.: ------
Autopsy results: ---------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --------- Date of: -----
Where did injury occur? ---------
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---------
Means of injury: --------- Injured at work? -----

23. SIGNATURE: Lloyd V. Hinkwood M. D. or other
Address: Crownsville, Maryland Date signed: 10/28/45

09754

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53a)

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
St. Johns College Infirmary
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For stillborn infant, give residence of mother)
State: Maryland County:
City or town: Conawongo
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Roger Clark Stone

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feby. 19. 1928

8. AGE:

Years	Months	Days	If less than one day
17	8	3	hrs. min.

9. Birthplace: Havre de Grace Maryland
(Town, county, and state)
10. Usual occupation: Student
11. Industry or business: St. John's College
FATHER 12. Name: Grant Stone
13. Birthplace: Columbus Ohio
MOTHER 14. Maiden name: Esther Clark
15. Birthplace: Brigham City, Utah.
16. Informant: M. Grant Stone.
Address: Conawongo Maryland.
17. (Burial, cremation, or removal. Which?) Cremation Date thereof: Oct 22 1945 (month) (day) (year)
Cemetery or crematory:
Location: Baltimore Md.
18. Funeral director: Hubert P. Harkins
Address: Delta Pa.
19. Oct. 22 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 22 19 45 at 1:00 P. M.
21. I CERTIFY that death occurred on the date above stated: [redacted] Postmortem 19 Examination from [redacted] 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	Sudden
Due to: Epilepsy	unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Caffey M.D., Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 10/22/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

09755

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arunde
City or town: Wesley Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Glenburnie Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Elizabeth Swick,

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 27, 1868

8. AGE: Years	Months	Days	If less than one day
76	10	6	..... hrs. ..... min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: School Teacher
FATHER 12. Name: Thomas F. Swick,
13. Birthplace: Baltimore, Md.
MOTHER 14. Maiden name: Elizabeth Zinkhan,
15. Birthplace: Baltimore, Md.
16. Informant: Mrs. Ann Woods,
Address: 5810 Gwynn Oak Ave.,
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/6/45 (month) (day) (year)
Cemetery or crematory: Cathedral Cem.
Location: Baltimore City,
18. Funeral director: C. Vernon Lemmon.
Address: 4611 Park Heights Ave., Baltimore, Md.
19. 10/5 (Date rec'd by registrar) 1945 A. W. Kidwell, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 3, 1945. 19..... at 9.30P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 15 19.45, to Oct 3- 19.45
and that I last saw her alive on Oct 1- 45 19.....

Immediate cause of death	DURATION
(a) Acute Coronary Thrombosis,	2 hours
Due to	
Due to	
Other conditions: Essential Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W. H. Lemmon M. D. or other
Address: Glenburnie Md. Date signed: Oct 4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

09756

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 years
Hospital, institution, or street address where death occurred:
16 College Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 16 College ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Bessie Thorogood

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Divorced

6.(b) Name of husband or wife:
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 1875

8. AGE: Years: 70 Months: 70 Days: If less than one day: ____ hrs. ____ min.

9. Birthplace: Annapolis A.A. Co. Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: None

FATHER
12. Name: Wm. Wills
13. Birthplace: Unknown

MOTHER
14. Maiden name: Isabella Cook
15. Birthplace: Annapolis

16. Informant: Mrs Sarah Hall
Address: 16 College Ave. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/14/45 (month) (day) (year)
Cemetery or crematory: Brewhill Cemetery
Location: West St. Rd.

18. Funeral director: Mrs Charles O. Hicks
Address: 45 Northwest St Annapolis Md.

19. Oct 12 1945 (Date rec'd by registrar) Mrs Tonnick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11, 1945, at 10:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2, 1945 to October 11, 1945
and that I last saw h-- alive on October 11, 1945

Immediate cause of death	DURATION
Cerebral Accident	
Due to Hypertension	7
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) ____
Means of injury: ____ Injured at work?

23. SIGNATURE: Dr. Theodore H. Johnson M.D.
M. D. or other
Address: 20 Northwest St. Date signed: 10/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
OCT 18 1945
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

09757

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 hours
Hospital, institution, or street address where death occurred:
USN Hospital, Annapolis
How long in hospital or institution? 6 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 179 Green St.
(If rural, give LOCATION)
2.(a) If veteran, name war World War II

3.(a) FULL NAME TOLBERT, GUS SAMUEL

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Edna Tolbert (wife)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1/12/08

8. AGE: Years 37 | Months 8 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace McLeansboro, Illinois
(Town, county, and state)

10. Usual occupation Bartender

11. Industry or business

FATHER 12. Name Samuel Tolbert
13. Birthplace Mt Vernon Ill

MOTHER 14. Maiden name Agnes Davis
15. Birthplace Mt Vernon Ill

16. Informant Mrs Gus S. Tolbert
Address 179 Green St, Annapolis, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 8/45 (month) (day) (year)

Cemetery or crematory Unknown

Location Mt. Vernon, Ill.

18. Funeral director B L Hopkins

Address Annapolis, Md.

19. Oct. 8 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7, 1945 19.... at 0010 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 6 1945, to Oct 7 1945 and that I last saw him alive on Oct 6, 1945 19....

Immediate cause of death	DURATION
Subdural Hematoma Rt. Frontal Region	? one week
Due to Cause unknown	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations No operations

Date of op. .....

Autopsy results Subdural Hematoma, Rt. Frontal

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H. C. Durant Lt (dr.) (MC) USNR
M. D. or other

Address U.S. Naval Hosp., Annapolis Date signed Oct 7, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

09758

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Gibson Island
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Florida County:
City or town: Winter Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Gertrude E. Trowbridge

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife: Alexander B. Trowbridge
6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): May 5. 1867

8. AGE: Years: 78 Months: 5 Days: 8 If less than one day: hrs. min.

9. Birthplace: Brooklyn New York (Town, county, and state)

10. Usual occupation: retired

11. Industry or business: Home

FATHER 12. Name: John Taylor Sherman
FATHER 13. Birthplace: Brooklyn. N.Y.

MOTHER 14. Maiden name: Julia Denning
MOTHER 15. Birthplace: Litchfield Conn

16. Informant: Mrs. Sherman Trowbridge
Address: 1412 - 29th St. N.W. Wash. D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 10/13/45 (month) (day) (year)

Cemetery or crematory:
Location: Washington D.C.

18. Funeral director: C. L. Hopkins
Address: Annapolis, Md.

19. 10-14 1945 L. E. Beck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 13 1945 at 4 45 P.M.

21. I CERTIFY that death occurred on the date above stated. Post-mortem Examination
Oct. 13 1945

	DURATION
Immediate cause of death: Coronary occlusion	Sudden
Due to: Coronary Sclerosis	unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John N. Laffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 10/13/45.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-e)

CERTIFICATE OF DEATH

09759

Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Lothrain
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Lothrain
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Joseph Emory Waters. **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feby 1926

8. AGE: Years: 19 Months: Days: If less than one day: hrs. min.

9. Birthplace: Lothrain, Anne Arundel Co., Md. (Town, county, and state)
10. Usual occupation: Farm Laborer
11. Industry or business: Farming

FATHER
12. Name: Thomas Waters
13. Birthplace: Calvert County, Md

MOTHER
14. Maiden name: Sarah Owens
15. Birthplace: Anne Arundel Co, Md

16. Informant: James Timms
Address: Lothrain, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 30/45 (month) (day) (year)
Cemetery or crematory: Mt Zion Cem.
Location: Lothian, Md

18. Funeral director: C. A. Stadtler Asst
Address: Galesville Md

19. 10/30 1945 (Date rec'd by registrar) H. R. Clayton Dep Asst Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 27, 1945 at 1:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I last attended deceased from Post mortem Examination on Oct. 27 1945; and that I last saw deceased on Oct. 27 1945

Immediate cause of death	DURATION
Penetrating wound Rt eye with brain	Sudden
Due to: piece of cast iron flying	
Due to: from broken pulley on tractor	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: Oct. 27, 1945
Where did injury occur? Lothrain (City or town), A. A. Co. (County), Maryland (State)
Injured at home, farm, industry, public place (where?): Farm
Means of injury: broken piece of pulley Injured at work? Yes.

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: Oct. 27 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(131-C)

09760

CERTIFICATE OF DEATH

★ Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Lothian
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Lothian
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME Thomas Waters

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	married

6.(b) Name of husband or wife: Sarah Waters
6.(c) If alive, give age: unknown ? years

7. Birth date of deceased (mo., day, yr.): 1865

8. AGE: Years	Months	Days	If less than one day
about 80			hrs. min.

9. Birthplace: Calvert Co. Md.
(Town, county, and state)

10. Usual occupation: Farmer Laborer

11. Industry or business

FATHER
12. Name: Thomas Waters Sr.
13. Birthplace: Calvert County

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Mrs. Raymond Cumtey
Address: Lothian

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Oct 30/45 (month) (day) (year)
Cemetery or crematory: Mt Zion Cem.
Location: Lothian, Md.

18. Funeral director: G. Gaudette & Son
Address: Galesville, Md.

19. 10/30 1945 (Date rec'd by registrar) W. P. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 29 1945, at 1 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 28 1945 to Oct 29 1945 and that I last saw h.. alive on Oct 28 1945

Immediate cause of death	DURATION
Myocarditis Chronic	?
Nephritis Chronic	?
Due to:	
Due to:	
Other conditions:	
Nose Complete Measles (Include pregnancy within 3 months of death)	2 yrs.

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F. B. Zeltzer M. D. or other
Address: Lothian Date signed 10/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

09761

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ft. Geo. G. Meade, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years and 9 months
Hospital, Institution, or street address where death occurred:
Auto Shop #1
How long in hospital or institution? Dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: —
City or town: Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.: —
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Henry S WILLIAMS

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ethel Williams
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 9, 1900

8. AGE: Years	Months	Days	If less than one day
45	5	3	— hrs. — min.

9. Birthplace: Huntley, Va. (Town, county, and state)
10. Usual occupation: Auto Mechanic
11. Industry or business: U. S. Government
MOTHER FATHER
12. Name: James Williams
13. Birthplace: Huntley, Va.
MOTHER
14. Maiden name: Laura North
15. Birthplace: Huntley, Va.
16. Informant: Mrs. Ethel M. Williams
Address: Savage, Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof October 11/45 (month) (day) (year)
Cemetery or crematory: Donaldson Funeral Home
Location: Laurel, Md.
18. Funeral director: [illegible]
Address: 105 Main St. Laurel Md.
19. October 11, 1945 (Date rec'd by registrar) FRANK J. TOLLISON, Registrar
Capt., MAC.

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11, 1945, at 3:07 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
viewed deceased XX XX XX
and that I last saw XXXXXXXXXXXX on or October 11, 1945

Immediate cause of death	DURATION
Coronary occlusion	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: None performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? (City or town) (County) (State) —
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: Edward Shaw M.D.
Capt. MC. M. D. or other
Address: Reg Hosp Ft Meade Md Date signed: Oct 11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09762

Reg. Diat. No. 21

1. PLACE OF DEATH: County: Anne Arundel Co. City or town: Simms Crossing Nr Annapolis (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? About 3 years Hospital, Institution, or street address where death occurred: Simms Crossing How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State: Maryland County: A. A. Co. City or town: Simms Crossing Nr. Annapolis (If outside city or town limits, write RURAL and give nearest town) Street No.: Near Annapolis Md. (If rural, give LOCATION) 2.(a) If veteran, name war:

3.(a) FULL NAME: Ollie Wilson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Mary Wilson 6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): 1893

8. AGE: Years	Months	Days	If less than one day
52	52		hrs. min.

9. Birthplace: Hopes Chapel A.A.Co Md. (Town, county, and state)

10. Usual occupation: farmer

11. Industry or business: None

FATHER 12. Name: Wm. Wilson

13. Birthplace: A. A. Co. Md.

MOTHER 14. Maiden name: Margaret Johnson

15. Birthplace: A. A. Co. Md.

16. Informant: Mrs Maggie Foote

Address: H Columbia Ave & West St Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/6/45 (month) (day) (year)

Cemetery or crematory: Fowlers Chapel Ameter

Location: Best Gate, Md.

19. Funeral director: Mrs Charles B. Hicks

Address: 45 Northwest St Annapolis Md.

19. Oct. 5 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 3 1945 at 8:40 A. M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem Examination 19 ~~to~~ and that I last saw him alive on Oct. 3 1945

Immediate cause of death	DURATION
Acute Dilatation of Heart	Sudden
Due to: Chronic myocarditis	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John N. Cathey M.D., Deputy Medical Examiner M. D. or other

Address: Annapolis, Md Date signed: 10/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09763

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Shady Side
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? unknown
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Shady Side
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Avalon Shores
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Herman Witte

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June, 1942

8. AGE: Years	Months	Days	If less than one day
3	6		hrs. min.

9. Birthplace: (Town, county, and state)
10. Usual occupation:
11. Industry or business
FATHER 12. Name: Karl H. Witte
13. Birthplace: Germany
MOTHER 14. Maiden name: madge J. Witte
15. Birthplace:
18. Informant:
Address:
17. Removal (Burial, cremation, or removal. Which?) Date thereof: oct 13/45 (month) (day) (year)
Cemetery or crematory: W. W Chambers
Location: Washington D. C.
18. Funeral director: W. W. Chambers
Address: 1400 Chapin Ct Washington
19. Oct 20 1945 (Date rec'd by registrar) D.B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 18 1945 at 8 30 P. M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem Examination 19
and that I last saw h~~im~~ alive on 19

Immediate cause of death	DURATION
Asphyxiation,	
Burned to death	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 10-18-45
Where did injury occur? at home Shady Side, A.R.Co., Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): home, Avalon Shores
Means of injury: Trapped in burning house Injured at work? No

23. SIGNATURE: John M. Clafty M.D Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md Date signed: 10-18-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09764 ★ Reg. Dist. No. 26

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Shady Side
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Shady Side
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Avalon Shores
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3. (a) FULL NAME: Karl H. Witte

3. (b) Social Security Number: 363-09-3572

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Madge
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 1 1907

8. AGE: Years	Months	Days	If less than one day
37	1	19	hrs. min.

9. Birthplace: Glod Bdc K[illegible] Germany
(Town, county, and state)
10. Usual occupation: owner.
11. Industry or business: Restaurant
FATHER 12. Name: HERMAN witte
13. Birthplace
MOTHER 14. Maiden name: ~~Madge witt~~
15. Birthplace
16. Informant
Address
17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 18/45 (month) (day) (year)
Cemetery or crematory: Chambers Funeral Home
Location: Washington D.C.
18. Funeral director: W. W. Chambers
Address: 1400 Chapin St. Washington DC.
19. Oct 20 1945 J. B. Dent
(Date rec'd by registrar) Regietrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 18 1945 at 8:30 P.M.
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Postmortem Examination
~~and that I last saw him~~ alive on Oct. 18 1945

Immediate cause of death	DURATION
Asphyxiation	
Burned to death	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 10-18-45
Where did injury occur? Shady Side (City or town) A.A. (County) Md. (State)
Injured at home, farm, industry, public place (where?) At home Avalon Shores
Means of injury: Trapped in burning house Injured at work? no

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md Date signed: 10-18-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

09765

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Fort George G. Meade Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Regional Hospital
How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D C County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4816 Rodman Street
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: Thomas R. WOOLFORD

3.(b) Social Security Number: 33 122 050

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife: Single
6.(c) If alive, give age: –
7. Birth date of deceased (mo., day, yr.): 10 December 1917

8. AGE: Years	Months	Days	If less than one day
27	9	26	– hrs. – min.

9. Birthplace: Portsmouth Va (Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business: U S Army

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Service Record
Address: U S Army

17. ~~Removal~~ Burial (Burial, cremation, or removal, Which?) Date thereof 10/13/45 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Alexandria Va.

18. Funeral director: Howard Blight
Address: 4914 Belair Rd, Baltimore Md

19. 12 October 1945 (Date rec'd by registrar) Frank J. Tollison (Registrar)
FRANK J. TOLLISON CAPT, MAC

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 October 1945, at 8:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19__, to 12 Oct. 1945
and that I last saw h.(.) alive on 12 Oct 1945

	DURATION
Immediate cause of death: Acute Cerebral vascular accident	
Due to: Embolism, basilar artery	
Due to: Subacute Bacterial endocarditis	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: –
Date of op.:
Autopsy results: Confirmed as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: – Date of:
Where did injury occur? – (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): –
Means of injury: – Injured at work? –

23. SIGNATURE: William B. Hagan
W B Hagan, MD (M. D. or other)
Address: Reg Hosp Ft Meade Md Date signed: 12 Oct 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING